

FAX FORM TO: 1.866.233.8317

PHONE: 1.855.492.0817

EMAIL: [contact@bluegrass-rx.com](mailto:contact@bluegrass-rx.com)

Complete the following or include demographic sheet.

1. PATIENT INFORMATION	
Name: _____	
Address: _____	
City, State, ZIP: _____	
Primary Phone: - -	DOB: / /
Alternate Phone: - -	Gender: _____
Email: _____	
Primary Language: _____	Last Four of SSN: _____

2. PRESCRIBER INFORMATION		
Name: _____		
DEA #: _____	NPI #: _____	State Lic. #: _____
Group or Hospital: _____		
Address: _____		
City, State, Zip: _____		
Phone: - -	Fax: - -	
Contact Person: _____	Phone: - -	

3. INSURANCE INFORMATION		<i>Fax copy of prescription and insurance cards with this form, if available (front and back)</i>	
Primary Insurance Company Name: _____		Secondary Insurance Company Name: _____	
Primary Cardholder Name: _____		Secondary Cardholder Name: _____	
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent		Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	
Phone: - -	Member ID: _____	Group #: _____	Phone: - -
			Member ID: _____
			Group #: _____

4. DIAGNOSIS AND CLINICAL INFORMATION	
Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	Patient has genetic marker: <input type="radio"/> G551D <input type="radio"/> f508del <input type="radio"/> Other:
<input type="radio"/> E84.9 Cystic fibrosis	Allergies: _____
<input type="radio"/> Other: _____	Current Medications: _____

5. PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Colistimethate kit (includes sterile water for injection, syringes, needles, and sharps container)				
<input type="radio"/> Hyper-Sal®	7%			
<input type="radio"/> Kalydeco	150 mg	Take 1 tablet by mouth twice daily.		
<input type="radio"/> Pulmozyme®	2.5 mg			
<input type="radio"/> TOBI® (LD)*	(LD)* These are limited distribution drugs that require additional handling. Please call (1.855.492.0817) for more information.			
<input type="radio"/> TOBIPODHALER (LD)*				
<input type="radio"/> Bethkis® (LD)*				
<input type="radio"/> Orkambi®	200mg-125mg tablet	Take 2 tablets by mouth every 12 hours with fat containing food.		
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE	
X _____ / /	X _____ / /
DISPENSE AS WRITTEN	PRODUCT SUBSTITUTION PERMITTED
DATE	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.